IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

June 4, 2010

Heather Davis
Home Again ICF
2311 Aruba Drive
Nampa, ID 83686

Provider #13G078

Dear Ms. Davis:

On **June 1, 2010**, a complaint survey was conducted at Home Again ICF. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004627

Allegation #1: Staff are using illegal drugs and are under the influence of alcohol while at work and the facility is doing nothing to address it.

Findings #1: An unannounced onsite complaint investigation was conducted on 6/1/10 and 6/2/10. During that time, observations, personnel records and the facility's drug testing policy were reviewed, and interviews with direct care and management staff were conducted with the following results:

Observations were conducted on 6/1/10 and 6/2/10 for a cumulative 3 hours 40 minutes. During that time, direct care staff were noted to appropriately interact with all eight (8) individuals residing in the facility. There was no indication of staff engaging in illicit drug use or being under the influence of alcohol during that time.

During the course of the survey, interviews were conducted with nine (9) direct care staff. All staff reported they had not witnessed nor did they have knowledge of staff using or being under the influence of illegal drugs or alcohol while at work. All staff consistently reported if they suspected such behavior, they would immediately notify management staff.

Additionally, two (2) management staff were interviewed during the survey. Both staff stated the facility had "zero tolerance" for drug and alcohol use as per the facility's 11/24/08 Drug Testing Policy. Both staff reported no staff had been drug tested since the opening of the facility as there was no suspicion or reason to do so. Twenty six (26) personnel records were reviewed and none of those records contained evidence of suspicion which would warrant drug testing per facility policy.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Individuals are left in urine soaked and soiled diapers for several hours at a time.

Findings #2: An unannounced onsite complaint investigation was conducted on 6/1/10 and 6/2/10. During that time, observations, record review, and interviews with direct care staff were conducted with the following results:

Observations were conducted on 6/1/10 and 6/2/10 for a cumulative 3 hours 40 minutes. During that time, all eight (8) individuals residing in the facility were noted to use the restroom independently. None of the individuals were noted to wear diapers or incontinent briefs.

During the course of the survey, interviews were conducted with nine (9) direct care staff. All staff stated all individuals were independent with toileting skills. Staff reported one individual chose to wear pull-ups to bed, and if there was a toileting accident, the individual independently cleaned and changed himself. Staff reported another individual occasionally required reminders to use the restroom.

Additionally, eight individuals' records were reviewed. Seven records showed the individuals were independent with toileting skills and one record showed an individual had a toileting program related to reminders to use the bathroom.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion:Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

BARBARA DERN
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

BD/srp

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Certified Mail: 7007 0710 0002 7979 0765

May 10, 2010

Heather Davis
Home Again ICF
2311 Aruba Drive
Nampa, ID 83686

RE: Home Again ICF, provider #13G078

Dear Ms. Davis:

Based on the Medicaid/Licensure survey completed at Home Again ICF on April 23, 2010, we have determined that Home Again ICF is out of compliance with the Medicaid Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) Condition of Participation on Client Behavior & Facility Practices (42 CFR 483.450). To participate as a provider of services in the Medicaid program, an ICF/MR must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this Condition to be unmet, substantially limit the capacity of Home Again ICF to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before **June 7, 2010. To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than May 27, 2010.**

The following is an explanation of a credible allegation:

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Home Again ICF is being issued a Provisional Intermediate Care Facility for Persons with Mental Retardation license. The license is enclosed and is effective April 23, 2010, through August 21, 2010. The conditions of the Provisional License are as follows:

1. Post the provisional license.
2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **June 4, 2010**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review. Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator
Division of Medicaid -- DHW
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 364-1804
fax: (208) 364-1811

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues which are not raised at an administrative review may not later be raised at higher level hearings (IDAPA 16.05.03.301).

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by May 20, 2010. If a request for informal dispute resolution is received after May 20, 2010 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

NW/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G078	A. BUILDING _____ B. WING _____	04/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME AGAIN ICF	2311 ARUBA DRIVE NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Barbara Dern, QMRP, Team Leader Monica Williams, QMRP Michael Case, LSW, QMRP Common abbreviations/symbols used in this report are: ADHD - Attention Deficit Hyperactivity Disorder CPI - A physical restraint system HRC - Human Rights Committee IBI - Intensive Behavior Intervention IDT - Interdisciplinary Treatment Team IEP - Individual Education Plan IPP - Individual Program Plan LPN - Licensed Practical Nurse NOS - Not Otherwise Specified OCD - Obsessive Compulsive Disorder ODD - Oppositional Defiant Disorder PBSP - Positive Behavior Support Plan QMRP - Qualified Mental retardation Professional RSM - Residential Service Manager	W 000	See attached Plan of Correction for survey dated 4-23-10 RECEIVED JUN 0 2 2010 FACILITY STANDARDS	
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to maintain a record keeping system that contained comprehensive information for 4 of 4 individuals (Individuals #1 - #4) whose records were	W 111		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heather R... TITLE: Administrator (X6) DATE: 6/2/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 111	Continued From page 1 reviewed. This resulted in a lack of consistent information being available. The findings include: 1. Individual #1's IPP, dated 3/10, documented a 15 year old male diagnosed with mild mental retardation, ODD, ADHD, schizoaffective disorder, reactive attachment disorder, and fetal alcohol effect. a. Individual #1's record did not contain information related to dental, vision, or hearing examinations. When asked, the LPN and Administrator both stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., the examinations were completed but the documentation could not be found. b. Individual #1's record contained counseling notes dated 12/09. However, his record contained no further information related to counseling. When asked, the Administrator and QMRP both stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., Individual #1 was currently receiving counseling on a weekly basis to assist him with managing his mood, coping with his mental illness, and coping with family relationships. They stated the facility needed to obtain copies of the counseling notes for Individual #1's record. c. Individual #1's Nursing Assessment, dated 3/30/10, documented that he received outside speech and occupational therapy. However, there was no further documentation in his record indicating he received such therapies. When asked, the Administrator stated during an	W 111		

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W 111	Continued From page 2 interview on 4/22/10 from 3:20 - 8:20 p.m., the Nursing Assessment referred to Individual #1's speech and occupational therapy evaluations, not actual therapy. d. Individual #1's record did not contain documentation related to who was invited and attended his IPP meeting. When asked, the Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., Individual #1's guardian, IBI therapist, the QMRP, and two direct care staff attended the IPP and his teacher participated via tele-conference. The Administrator stated all members of the team were invited. The Administrator stated there was no documentation of who was invited or attended his meeting. 2. Individual #3's IPP, dated 4/10, documented a 14 year old male diagnosed with mild mental retardation, pervasive developmental disorder, schizoaffective disorder, ADHD, and OCD. He was admitted to the facility on 2/16/10. a. Individual #3's record did not contain information related to dental, vision, or hearing examinations. When asked, the LPN and Administrator both stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., the examinations were delayed because there had been difficulty getting Medicaid approval for Individual #3. They stated they had just received the referral for these services. However, Individual #3's record did not contain documentation there had been difficulty obtaining	W 111		

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W 111	Continued From page 3 Medicaid approval. b. Individual #3's record contained an IEP dated 11/10/08. His annual update could not be found in his record. When asked, the QMRP stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., Individual #3's IEP was updated but they were not able to locate it. c. Individual #3's record did not contain documentation related to who was invited and attended his IPP meeting. When asked, the Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., Individual #3's guardians participated in his IPP via tele-conference. The Administrator stated, the QMRP, one direct care staff, and herself attended the IPP. The Administrator stated all members of the team were invited to attend the meeting. The Administrator stated there was no documentation of who was invited or attended the meeting. d. Individual #3's medical record showed he routinely received Thorazine (an antipsychotic drug) 100 mg three times daily, Abilify (an antipsychotic drug) 30 mg each night, and Trazodone (an antidepressant drug)150 mg each night. His record did not contain evidence that Individual #3's guardian and the facility's HRC reviewed and approved the use of all of his behavior modifying drugs. When asked, the Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., consents and approvals were obtained but	W 111		

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W 111	Continued From page 4	W 111		

the facility did not have documentation of them.

3. Individual #2's 1/10 IPP stated she was a 15 year old female whose diagnoses included mild mental retardation, mood disorder, a seizure disorder, and scoliosis. Individual #2 had a cervical spine fusion and a Harrington rod placed. She was admitted to the facility on 1/11/10. Individual #2's record did not contain complete information as follows:

a. Individual #2's record included a neurological consultation note, dated 1/25/10, that recommended a follow-up visit in two months. However, no documentation of a follow-up visit could be found at the time of the survey.

During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated the follow-up had been completed on 3/23/10, but documentation of the follow-up had not been obtained.

b. Individual #2's record included a postoperative evaluation, dated 12/3/09, for her spine fusion. The evaluation stated a follow-up was to be completed in two months. However, no documentation of a follow-up evaluation could be found at the time of the survey.

During an interview on 4/22/10 from 3:20 - 8:20 p.m., the LPN stated no follow up had not been completed because evidence had been presented at the time of admission documenting Individual #2 had been released by the physician. The LPN stated she was unable to find the documentation that released Individual #2 from the physician's care.

c. Individual #2's IPP included a service objective

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W 111	Continued From page 5 for weekly counseling visits by a Clinical Social Worker. Additionally, her record included a Service Plan, dated 12/8/09, for counseling needs. However, no documentation of weekly counseling sessions could be found in her record during the time of the survey. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator and LPN both stated Individual #2 attended weekly counseling sessions, but stated they had not obtained progress notes or counseling goals to be included in Individual #2's record. d. Individual #2's record did not contain documentation related to who was invited or attended her IPP meeting. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated Individual #2's IPP was attended by the Administrator, the QMRP, her guardians and one direct care staff. The Administrator stated there was no documentation or evidence of attendance at the IPP. e. Individual #2's record documented she was admitted to the facility on 1/11/10, and was receiving Paxil (an antidepressant drug) 20 mg each evening and Lamictal (an anticonvulsant drug) 25 mg twice daily from the time of admission. Individual #2's consents were reviewed and documented the following: - An HRC Approval Request Form for Paxil 20 mg each evening, dated 3/10/10, stated the drug was for mild mental retardation, reactive attachment disorder, depression, anxiety, mood disorder	W 111		

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W 111	Continued From page 6 NOS, pseudo epilepsy, and physical and verbal aggression. Attached to the form was an HRC Approval and Feedback Form, dated 3/10/10, and signed by the HRC. However, there was no documentation of HRC approval for the use of the drug prior to 3/10/10. Further, the form did not include documentation that the drug had been approved by his guardian. - An HRC Approval Request Form for Lamictal 100 mg each evening, dated 3/10/10, stated the drug was for mild mental retardation, reactive attachment disorder, depression, anxiety, mood disorder NOS, pseudo epilepsy, and physical and verbal aggression. The form contained the wrong dose of the drug and was signed by the Administrator and the LPN. The form did not include documentation that the drug had been approved by his guardian and the facility's HRC. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator and LPN both stated they believed HRC approval had been obtained within the first 30 days after admission but did not have documentation of the approval. 4. Individual #4's 3/10 IPP stated he was a 13 year old male whose diagnoses included mild mental retardation, bipolar mixed with psychotic features, ADHD, and mood disorder. He was admitted to the facility on 1/27/10. Individual #4's record did not contain complete information as follows: a. Individual #4's Comprehensive Functional Behavioral/Psychological Assessment and Medical Social Evaluation, dated 1/30/10, stated Individual #4 would need individual therapy on a weekly to bi-weekly basis to address	W 111		

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W 111	Continued From page 7 counseling/emotional needs. However, no documentation of counseling sessions could be found in his record during the time of the survey. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator and LPN both stated Individual #4 attended weekly counseling sessions, but stated they had not obtained progress notes or counseling goals to be included Individual #4's record. b. Individual #4's record did not contain documentation related to who was invited or attended his IPP meeting. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated Individual #4's IPP was attended by the Administrator, the QMRP, and his guardian. The Administrator stated Individual #4's mother provided input prior to the meeting. However, the Administrator stated there was no documentation or evidence of attendance at the IPP. c. His record documented he was admitted to the facility on 1/27/10, and was receiving Lithium Carbonate (a central nervous system drug) 300 mg twice daily, Prolixin (a antipsychotic drug) 5 mg in the morning and 10 mg in the evening, and Depakote (an anticonvulsant drug) 500 mg twice daily from the time of admission. Individual #4's consents were reviewed and documented the following: - An HRC Approval Request Form for Lithium Carbonate 300 mg twice daily, dated 3/10/10, stated the drug was for bipolar with psychotic features, oppositional defiant disorder, ADHD,	W 111		

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W 111	Continued From page 8 mild mental retardation, mood disorder NOS, and physical and verbal aggression. The form was signed by the Administrator and the LPN, but did not include documentation the drug had been approved by his guardian and the facility's HRC. - An HRC Approval Request Form for Prolixin 5 mg each morning and 10 mg each evening was dated 3/10/10. The form did not include information regarding the purpose of the drug. Additionally, the form was signed by the Administrator and the LPN, but did not include documentation the drug had been approved by his guardian and the facility's HRC. - An HRC Approval Request Form for Depakote 500 mg twice daily was dated 3/10/10. The form did not include information regarding the purpose of the drug. Additionally, the form was signed by the Administrator and the LPN, but did not include documentation the drug had been approved by the HRC. Further, the form was not signed by the guardian until 3/26/10. Additionally, there was no documentation that the guardian had given consent for the use of the drug prior to 3/26/10. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator and LPN both stated they believed HRC approval had been obtained within the first 30 days after admission but did not have documentation of the approval. The facility failed to ensure Individuals #1 - #4s' records contained comprehensive information.	W 111		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client,	W 124		

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W 124	Continued From page 9 parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure sufficient information was provided to parents/guardians on which to base consent decisions for 4 of 4 individuals (Individuals #1 - #4) whose written informed consents were reviewed. This resulted in a lack of information being provided to the individuals' guardians regarding restrictive interventions. The findings include: 1. Individual #4's 3/10 IPP stated he was a 13 year old male whose diagnoses include mild mental retardation, bipolar mixed with psychotic features, ADHD, and mood disorder. His record documented he received Prolixin (an antipsychotic drug) 5 mg each a.m. and 10 mg each p.m., Depakote (an anticonvulsant drug) 500 mg twice daily, and Lithium Carbonate (a central nervous system drug) 300 mg twice daily. Individual #4's consents were reviewed and documented the following: a. An HRC Approval Request Form for Lithium Carbonate 300 mg twice daily was dated 3/10/10. The form stated the drug was for bipolar with psychotic features, oppositional defiant disorder, ADHD, mild mental retardation, mood disorder NOS, and physical and verbal aggression. However, the form did not include the desired	W 124		

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W 124	Continued From page 10 outcome of the treatment, information regarding alternatives to the proposed treatment, information regarding a right to refuse treatment, possible consequences for refusal of treatment, or possible risks and side effects to the treatment. Additionally, the consent was not time-limited. b. An HRC Approval Request Form for Prolixin 5 mg each a.m. and 10 mg each p.m. was dated 3/10/10. However, the form did not include the diagnosis or behavior for which the drug was prescribed, the desired outcome of the treatment, information regarding alternatives to the proposed treatment, information regarding a right to refuse treatment, possible consequences for refusal of treatment, or possible risks and side effects to the treatment. The consent was not time-limited. c. An HRC Approval Request Form for Depakote 500 mg twice daily was dated 3/10/10. However, the form did not include the diagnosis or behavior for which the drug was prescribed, the desired outcome of the treatment, information regarding alternatives to the proposed treatment, information regarding a right to refuse treatment, possible consequences for refusal of treatment, or possible risks and side effects to the treatment. The consent was not time-limited. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator and LPN both stated the forms were the consent forms, and no additional information was present for Individual #4's written informed consents. The Administrator stated the information present was not sufficient for Individual #4's guardian to make informed	W 124		

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W 124	Continued From page 11 decisions regarding the treatments. The facility failed to ensure Individual #4's consents contained sufficient information for his guardian to make informed treatment decisions. 2. Individual #2's 1/10 IPP stated she was a 15 year old female whose diagnoses included mild mental retardation and mood disorder. Her record documented she received Paxil (an antidepressant drug) 20 mg each evening and Lamictal (an anticonvulsant drug) 25 mg twice daily. Individual #2's consents were reviewed and documented the following: a. An HRC Approval Request Form for Paxil 20 mg each evening was dated 3/10/10. The form stated the drug was for mild mental retardation, reactive attachment disorder, depression, anxiety, mood disorder NOS, pseudo epilepsy, and physical and verbal aggression. However, the form did not include the desired outcome of the treatment, information regarding alternatives to the proposed treatment, information regarding a right to refuse treatment, possible consequences for refusal of treatment, or possible risks of the treatment. The consent was not time-limited. Additionally, attached to the form was a sheet that stated Paxil was an antidepressant for anxiety disorders and PTSD (post traumatic stress disorder). The attached sheet gave a short list of side effects and stated "multiple drug interactions," but did not list the interactions, or if Individual #2 was receiving any drugs for which	W 124		

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W 124	Continued From page 12 interactions should be considered. b. An HRC Approval Request Form for Lamictal 100 mg each evening was dated 3/10/10. The form stated the drug was for mild mental retardation, depression, reactive attachment disorder, anxiety, mood disorder NOS, pseudo epilepsy, and physical and verbal aggression. Attached to the form was a sheet that stated Lamictal was an anticonvulsant which could be used to treat bipolar disorder, and gave a short list of side effects. Further, the dose of Lamictal was incorrect. The form did not include the desired outcome of the treatment, information regarding alternatives to the proposed treatment, information regarding a right to refuse treatment, possible consequences for refusal of treatment, or possible risks of the treatment. The consent was not time-limited. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator and LPN both stated the forms were the consent forms, and no additional information was present for Individual #2's written informed consents. The Administrator stated the information present was not sufficient for Individual #2's guardian to make informed decisions regarding the treatments. The facility failed to ensure Individual #2's consents contained sufficient information for her guardian to make informed treatment decisions. 3. Individual #3's IPP, dated 4/10, documented a 14 year old male diagnosed with mild mental retardation, pervasive developmental disorder, schizoaffective disorder, ADHD, and OCD. His	W 124		

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W 124	Continued From page 13 medical record showed he received Abilify (an antipsychotic drug) 30 mg each night, Thorazine (an antipsychotic drug) 100 mg three times daily, and Trazodone (an antidepressant drug) 150 mg each night. Individual #3's consents were reviewed and documented the following: a. An HRC Approval Request Form for Abilify 30 mg at night was dated 3/10/10. The form stated the drug was for schizoaffective disorder, self mutilation behaviors, autism, OCD, anxiety, and verbal and physical aggression. Additionally, attached to the form was a sheet that stated Abilify was for schizoaffective disorders and related behaviors. The attached sheet gave a short list of side effects. The form did not include the desired outcome of the treatment, information regarding alternatives to the proposed treatment, information regarding a right to refuse treatment, possible consequences for refusal of treatment, or possible risks to the treatment. The consnet was not time limited. b. An HRC Approval Request Form for Thorazine 100 mg three times daily was dated 3/10/10. The form stated the drug was for schizoaffective disorder, self mutilation behaviors, autism, OCD, anxiety, and verbal and physical aggression. Additionally, attached to the form was a sheet that stated Thorazine was for schizoaffective disorder and related behaviors. The attached sheet gave a short list of side effects.	W 124		

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W 124	Continued From page 14 The form did not include the desired outcome of the treatment, information regarding alternatives to the proposed treatment, information regarding a right to refuse treatment, possible consequences for refusal of treatment, or possible risks to the treatment. The consent was not time-limited. c. An HRC Approval Request Form for Trazodone 150 mg at night was dated 3/10/10. The form stated the drug was for schizoaffective disorder, self mutilation behaviors, autism, OCD, anxiety, and verbal and physical aggression. Additionally, attached to the form was a sheet that stated Trazodone was for schizoaffective disorder, depression, and insomnia. The attached sheet gave a short list of side effects. The form did not include the desired outcome of the treatment, information regarding alternatives to the proposed treatment, information regarding a right to refuse treatment, possible consequences for refusal of treatment, or possible risks to the treatment. The consnet was not time-limited. When asked, the Administrator and LPN both stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., the forms were the consent forms, and no additional information was present for Individual #3's written informed consents. The Administrator stated the information present was not sufficient for Individual #3's guardian to make informed decisions regarding his treatments. 4. Individual #1's IPP, dated 3/10, documented a 15 year old male diagnosed with mild mental retardation, ODD, ADHD, schizoaffective	W 124		

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W 124	Continued From page 15 disorder, reactive attachment disorder, and fetal alcohol effect. His record showed he received Prolixin (an antipsychotic drug) 7.5 mg twice daily and Risperidal (an antipsychotic drug) 1 mg three times daily. a. Individual #1's PBSP, dated 2/10, documented Prolixin was used to treat schizophrenia. Attached to his PBSP was a written consent. The consent did not include the desired outcome of the treatment, information regarding alternatives to the proposed treatment, information regarding a right to refuse treatment, possible consequences for refusal of treatment, or possible risks and side effects to the treatment. b. Individual #1's PBSP, dated 2/10, documented Risperidal was used to control aggression. Attached to his PBSP was a written consent. The consent did not include the desired outcome of the treatment, information regarding alternatives to the proposed treatment, information regarding a right to refuse treatment, possible consequences for refusal of treatment, or possible risks and side effects to the treatment. When asked, the Administrator and LPN both stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., there was no additional information for Individual #1's written informed consents. The Administrator stated the information present was not sufficient for Individual #1's guardian to make informed decisions regarding the treatments. The facility failed to ensure consents contained sufficient information for guardians to make informed treatment decisions for Individuals #1 -	W 124		

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W 124	Continued From page 16	W 124		
	#4.			
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure each individual was provided privacy in their bedroom for 2 of 8 individuals (Individuals #3 and #5) residing in the facility. This resulted in individuals dressing without adequate privacy. The findings include: 1. During an observation on 4/19/10 from 3:25 - 5:15 p.m., it was noted that Individual #5's bedroom window did not contain a curtain or blind. When asked, a staff present stated Individual #5 frequently tore his blinds from the window. The staff stated Individual #5 routinely dressed in his bedroom. During an environmental assessment on 4/22/10 from 10:00 a.m. - 12:20 p.m., it was noted Individual #5's bedroom was visible from three neighbors' back yards and a street. Additionally, Individual #5's bedroom had an attached bathroom consisting of a toilet and sink. The attached bathroom was without a door. When asked during an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated the blinds had been pulled down and replaced several times, but had not been replaced since the last time Individual #5 pulled them down. The	W 130		

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W 130	Continued From page 17 Administrator stated they needed to create a removable blind. 2. During an environmental assessment on 4/22/10 from 10:00 a.m. - 12:20 p.m., it was noted Individual #3's bedroom window did not have a curtain or blind. Individual #3's bedroom was noted to be visible from three neighbors' back yards and a street. Additionally, Individual #3's bedroom had an attached bathroom consisting of a toilet and sink. The attached bathroom was without a door. When asked during an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated the blinds had been pulled down and needed to be replaced. The Administrator stated they needed to create a removable blind. The facility failed to ensure Individual #3 and Individual #5's privacy was protected while in their bedrooms.	W 130		
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure individuals had access to personal possessions for 8 of 8 individuals (Individuals #1 - #8) whose personal items were observed to be inaccessible. This resulted in individuals not having access to their personal possessions.	W 137		

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W 137	Continued From page 18 The findings include: 1. During an observation on 4/19/10 from 6:15 - 8:08 p.m., it was noted that all 8 individuals' grooming kits were locked in the closet next to the kitchen. When asked, two of the staff present during the observation stated they did not know why grooming kits were locked. During an interview on 4/20/10 at 7:35 a.m., the Charge Staff stated all individuals' grooming kits were locked because they contained non-consumable fluids. When asked during an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated the grooming kits should not have been locked up. The facility failed to ensure individuals had access to their personal hygiene kits. 2. Individual #4's 3/10 IPP stated he was a 13 year old male whose diagnoses included mild mental retardation, bipolar mixed with psychotic features, ADHD, and mood disorder. During an observation on 4/19/10 from 3:25 - 5:15 p.m., Individual #4's toys were noted to be boxed and placed on a ledge 8 feet above the ground in his room. Individual #4 was not able to reach his toys. A staff present during the observation stated Individual #4 would throw his toys and use them as weapons, so staff were instructed to place the toys out of reach. When asked if Individual #4 had a plan related to toys being used as weapons, the staff stated they did not know. Individual #4's record did not contain	W 137		

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W 137	Continued From page 19 documentation regarding the restriction of his personal possessions. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator Individual #4's toys should not have been removed from him. The facility failed to ensure Individual #4 had access to his toys.	W 137		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure the QMRP provided sufficient monitoring and coordination which directly affected 8 of 8 individuals (Individuals #1 - #8) residing in the facility. That failure resulted in individuals not receiving the necessary assessments, objectives, and training required to meet their behavioral needs. The findings include: 1. An in-depth record review was conducted at the facility, on 4/21/10 from 9:00 a.m. - 3:50 p.m. for Individuals #1 - #4. At that time, documentation of QMRP monitoring could not be found from the opening of the facility on 8/19/09 to the date of the survey. When asked, the QMRP stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., he kept the information on an Excel spreadsheet and would fax that information to the survey team by	W 159		

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W 159	Continued From page 20 4/26/10. No information was received as of the writing of this report. 2. Refer to W111 as it relates to the facility's failure to ensure the QMRP ensured individuals' records contained accurate information. 3. Refer to W124 as it relates to the facility's failure to ensure the QMRP provided sufficient information to parents/guardians on which to base consent decisions. 4. Refer to W137 as it relates to the facility's failure to ensure the QMRP ensured individuals' personal possessions were not restricted. 5. Refer to W210 as it relates to the facility's failure to ensure the QMRP ensured individuals' assessments were conducted within 30 days of admission. 6. Refer to W214 as it relates to the facility's failure to ensure the QMRP ensured behavioral assessments were comprehensive and accurately identified individuals' behavioral status and needs. 7. Refer to W227 as it relates to the facility's failure to ensure the QMRP ensured objectives were developed to meet individuals' needs. 8. Refer to W231 as it relates to the facility's failure to ensure the QMRP ensured individuals' objectives contained measurable indices of performance. 9. Refer to W249 as it relates to the facility's failure to ensure the QMRP ensured individuals' plans were implemented as written.	W 159		

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W 159	Continued From page 21 10. Refer to W250 as it relates to the facility's failure to ensure the QMRP ensured active treatment schedules were sufficiently developed and individualized. 11. Refer to W288 as it relates to the facility's failure to ensure the QMRP ensured techniques to manage inappropriate behavior were not used as a substitute for an active treatment program. 12. Refer to W289 as it relates to the facility's failure to ensure the QMRP ensured techniques used to manage inappropriate behavior were incorporated into the program plans. 13. Refer to W312 as it relates to the facility's failure to ensure the QMRP ensured behavior modifying drugs were used only as a comprehensive part of an individuals' IPPs. 14. Refer to W436 as it relates to the facility's failure to ensure the QMRP ensured individuals had programs in place to teach them proper use of eyeglasses.	W 159		
W 210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure assessments were conducted within 30 days of	W 210		

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W 210	Continued From page 22 admission for 4 of 4 individuals (Individuals #1 - #4) admitted to the facility within the last 9 months. This resulted in insufficient information being available on which to base the development of functional IPPs. The findings include: 1. Individual #3's IPP, dated 4/10, documented a 14 year old male diagnosed with pervasive developmental disorder, schizoaffective disorder, ADHD, mild mental retardation, and OCD. He was admitted to the facility on 2/16/10. His record did not contain a physical therapy or an occupational therapy evaluation and there was no evidence they had been completed. When asked, the Administrator and LPN both stated during an interview on 4/22/10 from 3:30 - 8:20 p.m., the physical therapy evaluation was completed in 3/10 and the facility was waiting for the report. The Administrator stated the occupational therapy evaluation was completed on 4/16/10 and should have been completed within the first 30 days of admission. 2. Individual #1's IPP, dated 3/10, documented a 15 year old male diagnosed with mild mental retardation, ODD, ADHD, schizoaffective disorder, reactive attachment disorder, and fetal alcohol effect. He was admitted to the facility on 8/17/09. a. His record did not contain an occupational therapy evaluation and there was no evidence it had been completed. When asked, the Administrator stated during an interview on 4/22/10 from 3:30 - 8:20 p.m., the occupational therapy evaluation was completed	W 210		

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W 210	Continued From page 23 on 4/16/10 and should have been completed within the first 30 days of admission. b. Individual #1's record contained a physical therapy evaluation dated 11/15/09. When asked, the Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., the evaluation should have been completed within the first 30 days of admission. 3. Individual #2's 1/10 IPP stated she was a 15 year old female whose diagnoses included mild mental retardation, scoliosis (curvature of the spine), and syringomyelia (a disorder in which cysts form on the spine). Individual #2's record documented she had a cervical spine fusion and a Harrington rod placed in her spine. She was admitted to the facility on 1/11/10. a. Individual #2's record did not include a physical therapy evaluation or occupational therapy evaluation. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator and LPN both stated the physical therapy evaluation was completed 3/16/10 and the occupational therapy evaluation was completed 4/16/10, but the reports had not been received. The Administrator stated the evaluations were not completed within the first 30 days of admission but should have been. b. Individual #2's IPP stated she engaged in the following maladaptive behaviors: - Task avoidance (undefined). - Inappropriate boundaries (undefined). - Inappropriate sexual behaviors and ideations (undefined).	W 210		

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W 210	Continued From page 24 - Ignoring others when they speak to her. - Impulsive and inappropriate interactions (undefined). - Anger outbursts (undefined). - Teasing/taunting peers (undefined). However, Individual #2's record did not contain evidence of a behavioral assessment. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated a behavioral assessment had not been completed for Individual #2. 4. Individual #4's 3/10 IPP stated he was a 13 year old male whose diagnoses included mild mental retardation. He was admitted to the facility on 1/27/10. Individual #4's record did not include a physical therapy evaluation or occupational therapy evaluation, and the speech evaluation was dated 3/12/10. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator and LPN both stated the physical therapy evaluation did take place within the first 30 days, but the report had not been received. The Administrator stated the occupational therapy evaluation was not completed until 4/16/10, but should have been done within the first 30 days. The Administrator stated the speech evaluation was late due to an oversight. The facility failed to ensure assessments were completed for within the first 30 days of admission for Individuals #1 - #4.	W 210		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must	W 214		

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W 214	Continued From page 25 identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavioral assessments were completed and contained comprehensive information for 4 of 4 individuals (Individuals #1 - #4) whose behavior assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #3's IPP, dated 4/10, documented a 14 year old male diagnosed with mild mental retardation, pervasive developmental disorder, schizoaffective disorder, ADHD, and OCD. Individual #3's IPP documented he engaged in the following maladaptive behaviors: - Hitting and scratching himself. - Pulling his own hair. - Verbally abusive to authority figures (undefined). - Physically abusive to authority figures (undefined). Individual #3's record documented he received Thorazine (an antipsychotic drug) 100 mg three times daily and Abilify (an antipsychotic drug) 30 mg each night. However, Individual #3's record did not contain a behavioral assessment or information related to a description of the maladaptive behaviors, analyses of the potential causes, and the psychological, physiological, environmental, or social conditions which were eliciting or sustaining the behaviors.	W 214		

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W 214	Continued From page 26 When asked, the Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., a behavior assessment was completed by Individual #3's counselor. The Administrator stated a copy of this assessment had not been received. The facility failed to ensure Individual #3's record contained a behavioral assessment. 2. Individual #1's IPP, dated 3/10, documented a 15 year old male diagnosed with mild mental retardation, ODD, ADHD, schizoaffective disorder, reactive attachment disorder, and fetal alcohol effect. Individual #1's Comprehensive Functional Behavioral/Psychological Assessment and Medical Social Evaluation, dated 9/11/09, included a section titled "Socially" which stated Individual #1 would "have a 'behavior' which consists of yelling, swearing, sometimes running away and he has at times hit others, seriously injuring them." However, his PBSP, dated 2/10, documented he engaged in threatening staff, eloping, making suicidal gestures, and destruction to property. Individual #1's Assessment was not consistent with his PBSP. Further, his Assessment did not include a comprehensive analyses of the potential causes, or the psychological, physiological, environmental, or social conditions which were eliciting or sustaining the behaviors. When asked, the Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., the	W 214		

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W 214	Continued From page 27 behavior assessment needed to be revised. The facility failed to ensure Individual #1's behavioral assessment was sufficiently developed and contained comprehensive information. 3. Individual #2's 1/10 IPP stated she was a 15 year old female whose diagnoses included mild mental retardation and mood disorder. She was admitted to the facility on 1/11/10. Individual #2's IPP stated she engaged in the following maladaptive behaviors: - Task avoidance (undefined). - Inappropriate boundaries (undefined). - Inappropriate sexual behaviors and ideations (undefined). - Ignoring others when they speak to her. - Impulsive and inappropriate interactions (undefined). - Anger outbursts (undefined). - Teasing/taunting peers (undefined). However, Individual #2's record did not contain documentation of a behavioral assessment or information related to a description of the maladaptive behaviors, analyses of the potential causes, and the psychological, physiological, environmental, or social conditions which were eliciting or sustaining the behaviors. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated a behavioral assessment had not been completed for Individual #2. The facility failed to ensure a behavioral assessment had been completed for Individual #2.	W 214		

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W 214	Continued From page 28 4. Individual #4's 3/10 IPP stated he was a 13 year old male whose diagnoses included mild mental retardation, bipolar mixed with psychotic features, ADHD, and mood disorder. Individual #4's IPP stated he engaged in the following maladaptive behaviors: - Verbal and physical aggression towards others (undefined). - Inappropriate attention seeking (defined as poking others). - Task avoidance (undefined). - Elopement (undefined). A Comprehensive Functional Behavioral/Psychological Assessment and Medical Social Evaluation, dated 1/30/10, included a section titled "Functional Assessment Skills to manage [sic] Developmental Disability and Mental Illness" which stated Individual #4 did not understand his mental illness, had attempted to hurt others, and could become impulsive and aggressive very quickly. The Assessment was not consistent with Individual #4's IPP. Further, the Assessment did not include information related to the analyses of the potential causes, or the psychological, physiological, environmental, or social conditions which were eliciting or sustaining the behaviors. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated the information in Individual #4's assessment was not sufficient. The facility failed to ensure Individual #4's behavioral assessment was sufficiently developed and contained comprehensive information.	W 214		

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W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure individuals' IPPs included objectives to meet their needs for 5 of 5 individuals (Individuals #1 - #5) whose IPPs and objectives were reviewed. This resulted in a lack of program plans designed to address the needs of the individuals in areas most likely to impact their lives. The findings include: 1. Individual #4's 3/10 IPP stated he was a 13 year old male whose diagnoses included mild mental retardation, bipolar mixed with psychotic features, ADHD, and mood disorder. a. Individual #4's record documented he received Prolixin (an antipsychotic drug) 5 mg in the morning and 10 mg in the evening, Depakote (an anticonvulsant drug) 500 mg twice daily, and Lithium Carbonate (a central nervous system drug) 300 mg twice daily. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated Prolixin, Depakote, and Lithium Carbonate were for his bipolar disorder. The Administrator stated Individual #4's bipolar disorder presented as mania, agitation, tantrums including screaming, kicking, and spitting, aggression, and destruction of property. The Administrator stated Individual #4's mood	W 227		

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W 227	Continued From page 30 disorder presented as inappropriate emotional responses. However, objectives for the maladaptive behaviors noted above were not present in his IPP. Additionally, his IPP stated "See PBSP for Behavior Goals." However, a PBSP could not be found. b. Individual #4's IPP stated he engaged in the following maladaptive behaviors: - Verbal and physical aggression towards others (undefined). - Inappropriate attention seeking (defined as poking others). - Task avoidance (undefined). - Elopement (undefined). However, Individual #4's IPP did not include objectives to address his maladaptive behaviors. c. During observations on 4/19/10 from 3:25 - 5:15 p.m. and 6:15 - 8:08 p.m., and on 4/20/10 from 6:15 - 7:40 a.m., it was noted Individual #4's door latch was covered with duct tape preventing the door from latching shut. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated Individual #4 would enter his room, lock the door, and attempt to hurt himself or destroy property. Objectives related to self injurious behavior and property destruction could not be found in Individual #4's record. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated Individual #4 did not have a PBSP and behavioral objectives had not been developed.	W 227		

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W 227	Continued From page 31 The facility failed to ensure objectives were developed to meet Individual #4's behavioral needs. 2. Individual #2's 1/10 IPP stated she was a 15 year old female whose diagnoses included mild mental retardation and mood disorder. Individual #2's record documented she received Paxil (an antidepressive drug) 20 mg each evening. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated Paxil was used for anxiety. When asked about an objective for anxiety, the Administrator stated one had not been developed because they did not see anxiety as a maladaptive behavior. The facility failed to ensure an objective related to Individual #2's anxiety had been developed. 3. Individual #5's 10/09 IPP stated he was a 12 year old male whose diagnoses included mild mental retardation, mood disorder, ADHD, ODD, and anxiety disorder NOS. a. An Significant Event Report, dated 2/25/10, stated Individual #5 made a suicide attempt by wrapping items (a towel, a belt, and sweaters) around his neck. However, his IPP did not include objectives related to suicidal ideation. b. During observations on 4/19/10 from 3:25 - 5:15 p.m. and 6:15 - 8:08 p.m., and on 4/20/10 from 6:15 - 7:40 a.m., it was noted Individual #5's door latch was covered with duct tape preventing the door from latching shut. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated Individual #5 would	W 227		

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W 227	Continued From page 32 enter his room, lock the door, and attempt to hurt himself or destroy property. Objectives related to self injurious behavior were not found in Individual #5's IPP. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated objectives related to self injurious behavior and suicidal ideation had not been developed for Individual #5. The facility failed to ensure objectives for Individual #5's self injurious behavior and suicidal ideation had been developed. 4. Individual #3's IPP, dated 4/10, documented a 14 year old male diagnosed with mild mental retardation, pervasive developmental disorder, schizoaffective disorder, ADHD, and OCD. a. Individual #3's record documented he received received Thorazine (an antipsychotic drug) 100 mg three timer per day, Abilify (an antipsychotic drug) 30 mg at night, and Trazodone (an antidepressant drug) 150 mg at night. When asked, the Administrator and LPN stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., Individual #3 received Thorazine and Abilify for aggression and Trazodone for sleep. When asked about objectives related to aggression and sleep, the Administrator stated objectives had not been developed. b. Individual #3's Speech Language Evaluation, dated 3/18/10, included recommendations to increase utterance length, reduce rate of speech, and demonstrate an understanding of abstract language.	W 227		

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W 227	Continued From page 33 However, Individual #3's IPP did not include objectives related to his communication needs. When asked, the Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., objectives needed to be developed to meet Individual #3's communication needs. c. Individual #3's IPP documented he engaged in the following maladaptive behaviors: - Hitting and scratching himself. - Pulling his own hair. - Verbally abusive to authority figures (undefined). - Physically abusive to authority figures (undefined). However, his IPP did not include objectives to address the maladaptive behaviors. When asked, the Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., objectives had not been developed for Individual #3. d. Individual #3's IPP listed the following priority needs which were not incorporated into objectives: - "[Individual #3] will make healthy snack choices." - "[Individual #3] will remove himself from over stimulating environments to the extent that it is possible." - "[Individual #3] will remain in control when he becomes frustrated or angered by others. [Individual #3] will remove himself from a frustrating situation in a socially appropriate	W 227		

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W 227	Continued From page 34 manner rather than lash out at those around him." - "[Individual #3] will slow his speech in order for those around him to understand what he is saying." - "[Individual #3] will respect the boundaries of others." When asked, the Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., objectives needed to be developed to meet Individual #3's priority needs. The facility failed to ensure objectives were developed to meet Individual #3's needs. 5. Individual #1's IPP, dated 3/10, documented a 15 year old male diagnosed with mild mental retardation, ODD, ADHD, schizoaffective disorder, reactive attachment disorder, and fetal alcohol effect. a. Individual #1's speech evaluation, dated 10/5/09, included recommendations to work on increasing utterance length, use appropriate social communication, and demonstrate an understanding of abstract language. However, Individual #1's IPP did not include objectives related to his communication needs. When asked, the Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., objectives needed to be developed to meet Individual #1's communication needs. b. His IPP listed the following priority needs which were not incorporated into objectives:	W 227		

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W 227	Continued From page 35 - "[Individual #1] will learn meal preparation." - "[Individual #1] will learn time management skills." - "[Individual #1] will use appropriate social communication at home, at school and in the community. He will demonstrate the ability to use communication skills to enhance his health." - "[Individual #1] requires extensive support, direction, and interventions in building his independent adaptive skills, communication skills, managing emotions and behavior dyscontrol [sic]." - "[Individual #1] will identify appropriate staff and peer interactions. [Individual #1] will control his sexually inappropriate behavior." - "[Individual #1] will develop good working skills by attending all of his classes, being on time, completing tasks/assignments, following directions, and making up work as needed." When asked, the Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., objectives needed to be developed to meet Individual #1's needs. The facility failed to ensure objectives were developed to meet Individual #1's needs.	W 227		
W 231	483.440(c)(4)(iii) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance.	W 231		

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W 231	Continued From page 36 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the objectives of the IPP were behaviorally stated in measurable terms so as to accurately monitor progress towards the objectives for 2 of 5 individuals (Individuals #1 and #4) whose IPPs and program objectives were reviewed. This resulted in individuals participating in activities for which progress and regression could not be assessed. The findings include: 1. Individual #4's 3/10 IPP stated he was a 13 year old male whose diagnoses included mild mental retardation, bipolar mixed with psychotic features, ADHD, and mood disorder. His IPP included a list of formal objectives which were not expressed in behaviorally stated, measurable terms. Examples included, but were not limited to, the following: a. "[Individual #4] will brush his teeth 8 out of 10 times by 3/11." It was not clear if the criteria was 8 out of 10 times a day, week, month, or year and whether he was to brush his teeth independently or with prompts. b. "[Individual #4] will seek attention from others by asking for it in an appropriate manner 5 out of 7 times weekly by 3/11." It was not clear what "seek attention" and "an appropriate manner" meant for Individual #4. c. "[Individual #4] will self-isolate when he is having difficulty dealing with his emotions 3 out of 8 times by 6/10." It was not clear if the criteria was 3 out of 8 times a day, week, month, or year.	W 231		

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W 231	Continued From page 37 Further, it was not clear if he was to self isolate independently or with prompts. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated the objectives were not measurable and needed to be revised for clarification. 2. Individual #1's IPP, dated 3/10, documented a 15 year old male diagnosed with mild mental retardation, ODD, ADHD, schizoaffective disorder, reactive attachment disorder, and fetal alcohol effect. His IPP included a list of formal objectives which were not expressed in behaviorally stated, measurable terms. Examples included, but were not limited to, the following: a. "Independently, [Individual #1] will learn to self administer his prescribed medications through an established program overseen by [facility name] nursing and medical staff 5 out of 7 trials per week by 6/2010, as measured by direct care staff and QMRP training data." It was not clear what was included in the "established program" or what "will learn" meant. b. "Independently, [Individual #1] will initiate appropriate social interactions 4 out of 5 trials per week by 3/11 as measured by direct care staff and QMRP training data." It was not clear what "initiate" and "appropriate social interactions" meant. c. "[Individual #1] will independently brush his teeth in the morning 5 out of 7 times by 3/11, as measured by direct care staff and the QMRP." It was not clear if the criteria was 5 out of 7 times a	W 231		

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W 231	Continued From page 38 day, week, month, or year. When asked, the Administrator and QMRP stated during an interview on 4/22/10 from 3:20 - 8:30 p.m., the objectives needed to be revised. The facility failed to ensure objectives were written in measurable terms for Individuals #1 and #4.	W 231		
W 234	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by:	W 234		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure each individual received training and services consistent with their IPP for 2 of 3 individuals (Individuals #5 and #6) who required one-to-one supervision. This resulted in individuals not receiving supervision as specified in their IPPs. The findings include:	W 249		

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W 249	Continued From page 39 1. Individual #5's 10/09 IPP stated he was a 12 year old male whose diagnoses included mild mental retardation, mood disorder, ADHD, ODD, and anxiety disorder NOS. Individual #5's PBSP, dated 2/10, stated he "requires intensive, arm's length, one to one supervision 24 hours a day by specially trained staff members" due to violent and aggressive behaviors. However, during a cumulative 5 hours 8 minutes of observation on 4/19/10 and 4/20/10, it was noted that Individual #5 was not consistently within arms-length of staff. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated Individual #5 was to always be within arms-length of staff. 2. Individual #6's IPP, dated 11/09, documented a 10 year old male diagnosed with severe autism and ADHD. His PBSP, dated 2/10, stated "[Individual #6] requires continuous, one-to-one supervision 24 hours a day." One-to-one supervision was not clearly defined. However, during a cumulative 5 hours 8 minutes of cumulative observation on 4/19/10 and 4/20/10, it was noted that Individual #6 was not consistently kept within arm's length or line of sight. When asked, the Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., Individual #6 required a one-to-one staff due to his high energy level and with his activities of daily	W 249		

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W 249	Continued From page 40 living. The Administrator stated one-to-one staffing should have been consistently implemented with Individual #6. The facility failed to ensure Individual #5 and #6's one-to-one staffing was consistently implemented.	W 249		
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to develop active treatment schedules sufficient to direct staff for 4 of 4 individuals (Individuals #1 - #4) whose active treatment schedules were reviewed. Failure to ensure schedules were sufficient and flexible enough to direct staff in their efforts to address individuals' active treatment needs had the potential to seriously impede the facility's ability to provide such services to the individuals. The findings include: 1. Individual #1 - #4's active treatment schedules, undated, were reviewed. It was noted the schedules were identical and included the following: Each schedule consisted of a grid listing times and tasks down the left hand side and days of the week across the top. A space at the top stated "Week of:" and allowed staff to document dates. The following times and activities were listed:	W 250		

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W 250	Continued From page 41 - 6:00 - 9:00 a.m.: shower, get dressed, hygiene routine, breakfast. - 9:00 - 11:00 a.m. "Or (7:00 am - 9:00 pm [sic] on school days)": make bed, clean room, vacuum room, clean resident bathroom, change sheets, prepare snack. - 12:00 - 1:30 p.m.: help prepare lunch, clean up after lunch. - 1:30 - 2:30 p.m.: physical activity. - 2:30 - 4:00 p.m.: prepare snack, art activity. - 4:00 - 5:30 p.m.: homework/cognitive objectives, guided free choice time. - 5:30 - 7:00 p.m.: help set table, help cook dinner, clean up after dinner, resident's meeting. - 7:00 - 9:00 p.m.: reading time, hygiene routine, dress for bed. The schedules were not individualized; they did not contain individuals' formal and informal training plans, individuals' likes and dislikes, instructions to staff on what to do if an individual refused to participate, or what to do if the individuals finished the task before its allotted time. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the LPN, RSM, and QMRP all stated the active treatment schedules were not individualized. The facility failed to ensure Individual #1 - #4's	W 250		

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W 250	Continued From page 42 active treatment schedules were adequately developed.	W 250		
W 266	483.450 CLIENT BEHAVIOR & FACILITY PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by: Based on observation, review of the facility's policies and procedures, record review, and individual and staff interviews it was determined the facility failed to ensure that techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. This failure resulted in individuals not receiving appropriate behavioral services and interventions. The findings include: 1. Refer to W214 as it relates to the facility's failure to ensure behavioral assessments were comprehensive and accurately identified individuals' behavioral status and needs. 2. Refer to W227 as it relates to the facility's failure to ensure individuals' IPPs included objectives to meet their behavioral needs. 3. Refer to W249 as it relates to the facility's failure to ensure individuals' behavior plans were implemented as written. 4. Refer to W276 as it relates to the facility's failure to ensure the maladaptive behavior policy was adequately developed to include all positive and intrusive behavior interventions on a	W 266		

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W 266	Continued From page 43 hierarchy ranging from most positive to most intrusive. 5. Refer to W288 as it relates to the facility's failure to ensure techniques to manage inappropriate behavior were not used as a substitute for an active treatment program. 6. Refer to W289 as it relates to the facility's failure to ensure techniques used to manage inappropriate behavior were incorporated into the program plans. The cumulative effect of these negative facility practices significantly impeded the ability of the facility to provide services to meet the behavioral needs of individuals residing in the facility.	W 266		
W 276	483.450(b)(1)(i) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Policies and procedures that govern the management of inappropriate client behavior must specify all facility approved interventions to manage inappropriate client behavior. This STANDARD is not met as evidenced by: Based on review of the facility's behavior policy, record review, and staff interview it was determined the facility failed to ensure the behavior policy included all interventions used to manage maladaptive behavior which directly impacted 1 of 4 individuals (Individual #3) whose records were reviewed, and had the potential to impact 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in interventions being used that were not approved for use. Findings include:	W 276		

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W 276	Continued From page 44 1. Individual #3's IPP, dated 4/10, documented a 14 year old male diagnosed with mild mental retardation, pervasive developmental disorder, schizoaffective disorder, ADHD, and ODD. Individual #3's record included a written agreement, dated 2/16/10, titled "Client Caused Damage To Facility Property." The agreement stated "Residents or their parents/legal guardians will be financially responsible for reimbursing [Facility Name] for damage to facility property caused by residents." It further stated that residents' personal spending money would be used if their parents/legal guardians chose not to pay. However, the facility's Hierarchy of Behavioral Interventions policy, undated, did not include individuals or their parents/guardians reimbursing the facility for damaged property. When asked, the Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., individuals received an allowance of $10.00 a week from facility funds and did not use their personal funds. The Administrator stated if property destruction occurred, the individual received an allowance of only $2.00 until the damages were paid. The Administrator stated Individual #3's agreement needed to be revised as well as the Behavior Interventions policy. The facility failed to ensure all behavioral interventions were included in the policy.	W 276		
W 288	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used as a substitute for	W 288		

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W 288	Continued From page 45 an active treatment program. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure techniques to manage inappropriate behavior were not used as a substitute for an active treatment program for 2 of 4 individuals (Individuals #3 and #4) whose records were reviewed. This resulted in restrictive interventions being utilized without training programs in place to teach individuals appropriate behavior. Findings include: 1. Individual #4's 3/10 IPP stated he was a 13 year old male whose diagnoses included mild mental retardation, bipolar mixed with psychotic features, ADHD, and mood disorder. a. Individual #4's record included a Behavior Contract, dated 4/15/10, which was signed by Individual #4, a direct care staff, and the QMRP. The Behavior Contract stated Individual #4 would be removed from the facility and placed in a psychiatric hospital if he physically assaulted staff. Individual #4's record did not contain a plan related to physical assaults or the use of a Behavior Contract. Additionally, the facility's behavior policy did not include the use of a Behavior Contract. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated Individual #4 did not have a program to address physical aggression. The QMRP, who was present during the interview, stated the Behavior Contract was a	W 288		

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W 288	Continued From page 46 "knee jerk" reaction and an "empty threat." The Administrator stated the Behavior Contract was not approved in policy and should not have been used. b. During an observation on 4/19/10 from 3:25 - 5:15 p.m., Individual #4's toys were noted to be boxed and placed on a ledge 8 feet above the ground in his room. Individual #4 was not able to reach his toys. A present staff during the observation stated Individual #4 would throw his toys and use them as weapons, so staff were instructed to place the toys out of reach. When asked if Individual #4 had a plan related to toys being used as weapons, the staff stated they did not know. Individual #4's record did not contain a plan related to the use of toys as weapons or instructions directing staff to place his toys out of reach. Additionally, Individual #4's record did not contain consents allowing such action. Further, the facility's behavior policy did not include removal of an individual's toys as an approved behavioral intervention. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated Individual #4 did not have a program to address his maladaptive behavior of using toys as weapons, and removing his toys should not have occurred. 2. Individual #3's IPP, dated 4/10, documented a 14 year old male diagnosed with mild mental retardation, pervasive developmental disorder, schizoaffective disorder, ADHD, and ODD. Individual #3's record included a written agreement, dated 2/16/10, titled "Client Caused	W 288		

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W 288	Continued From page 47 Damage To Facility Property." The agreement stated "Residents or their parents/legal guardians will be financially responsible for reimbursing [Facility Name] for damage to facility property caused by residents." It further stated that residents' personal spending money would be used if their parents/legal guardians chose not to pay. The agreement stated a PBSP would be in place to address the individual's destructive behavior. However, Individual #3's record did not contain a PBSP related to property damage. When asked, the Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., Individual #3 did not have a PBSP related to property damage. The facility failed to ensure techniques to manage Individual #3 and #4s' maladaptive behaviors were not used as substitutions for active treatment programs designed to address the behaviors.	W 288		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure techniques used to manage inappropriate	W 289		

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W 289	Continued From page 48 behavior were incorporated into the program plans for 5 of 6 individuals (Individuals #2, #3, #4, #5, and #6) whose behavior support plans were reviewed. This resulted in interventions being used that were not included in the individuals' behavior management programs. The findings include: 1. Individual #3's IPP, dated 4/10, documented a 14 year old male diagnosed with mild mental retardation, pervasive developmental disorder, schizoaffective disorder, ADHD, and obsessive compulsive disorder. Individual #3's record included a written agreement, dated 2/16/10, titled "Client Caused Damage To Facility Property." The agreement stated "Residents or their parents/legal guardians will be financially responsible for reimbursing [Facility Name] for damage to facility property caused by residents." It further stated that residents' personal spending money would be used if their parents/legal guardians chose not to pay. The agreement stated a PBSP would be in place to address the individual's destructive behavior. However, Individual #3's record did not contain a PBSP related to property damage. When asked, the Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., Individual #3 did not have a PBSP. 2. Individual #6's IPP, dated 11/09, documented a 10 year old male diagnosed with severe autism and ADHD. His PBSP, dated 2/10, stated "[Individual #6] requires continuous, one-to-one supervision 24	W 289		

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W 289	Continued From page 49 hours a day." However, the plan did not clearly identify what one-to-one meant for Individual #6. Further, Individual #6's PBSP stated staff were to use a CPI Child or CPI Team Restraint when he exhibited an angry emotional outburst which could include self injurious and destructive behaviors. However, the PBSP did not identify when each restraint was to be used. When asked, the Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., Individual #6 required a one-to-one staff to assist him in activities of daily living and he could have private time in his room when requested. Further, she stated that his PBSP needed to be revised to clarify the specific restraint methods to be used. 3. Individual #2's 1/10 IPP stated she was a 15 year old female whose diagnoses included mild mental retardation and mood disorder. Individual #2's IPP stated she engaged in the following maladaptive behaviors: - Task avoidance (undefined). - Inappropriate boundaries (undefined). - Inappropriate sexual behaviors and ideations (undefined). - Ignoring others when they speak to her. - Impulsive and inappropriate interactions (undefined). - Anger outbursts (undefined). - Teasing/taunting peers (undefined). However, Individual #2's record did not include plans to address her identified maladaptive behaviors. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated a behavior plan had been developed but was not	W 289		

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W 289	Continued From page 50 available to staff. The Administrator stated staff were relying on verbal instructions to address Individual #2's maladaptive behaviors. 4. Individual #4's 3/10 IPP stated he was a 13 year old male whose diagnoses included mild mental retardation, bipolar mixed with psychotic features, ADHD, and mood disorder. During observations on 4/19/10 from 3:25 - 5:15 p.m. and 6:15 - 8:08 p.m., and on 4/20/10 from 6:15 - 7:40 a.m., it was noted Individual #4's door latch was covered with duct tape preventing the door from latching shut. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated Individual #4 would enter his room, lock the door, and attempt to hurt himself or destroy property. However, no plan incorporating the technique could be found in Individual #4's record. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated a plan had not been developed. 5. Individual #5's 10/09 IPP stated he was a 12 year old male whose diagnoses included mild mental retardation, mood disorder, ADHD, ODD, and anxiety disorder NOS. a. During observations on 4/19/10 from 3:25 - 5:15 p.m. and 6:15 - 8:08 p.m., and on 4/20/10 from 6:15 - 7:40 a.m., it was noted Individual #5's door latch was covered with duct tape preventing the door from latching shut. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated Individual #5 would	W 289		

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W 289	Continued From page 51 enter his room, lock the door, and attempt to hurt himself or destroy property. Individual #5's PBSP, dated 2/10, did not incorporate the use of the tape. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated the technique was not incorporated into a plan. b. Individual #5's PBSP, dated 2/10, stated "If [Individual #5's] behaviors present an immediate risk to himself or others, staff will manually restrain him using the CPI Child or Team Restraint until he no longer poses a threat to himself or others." However, the plan did not provide clear direction as to when staff were to use the CPI Child verses the Team Restraint. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated the CPI Child restraint was a 1 person restraint and the Team Restraint was a 2 person restraint. The Administrator stated the 2 person restraint was the preferred method, but the 1 person restraint could be used if no other staff were available, such as in the community, out in the yard, etc. The Administrator stated the plan needed to be revised. The facility failed to ensure techniques used to manage inappropriate behavior were specific and incorporated into the program plans for Individuals #2 - #6.	W 289		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the	W 312		

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W 312	Continued From page 52 client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of the individuals' IPPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 4 of 4 individuals (Individuals #1 - #4) whose medication reduction plans were reviewed. This resulted in individuals receiving behavior modifying drugs without plans that identified the drugs usage and how they may change in relation to progress or regression. The findings include: 1. Individual #2's 1/10 IPP stated she was a 15 year old female whose diagnoses included mild mental retardation, mood disorder, and a seizure disorder. Her record documented she received Paxil (an antidepressant drug) 20 mg each evening and Lamictal (an anticonvulsant drug) 25 mg twice daily. A physician's Progress Note, dated 10/1/09, stated Paxil and Lamictal were prescribed to treat Individual #2's mood disorder. However, her record did not contain a plan related to the use of the drugs. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated Individual #2 exhibited signs and symptoms of anxiety, but stated plans for anxiety, including a plan related	W 312		

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W 312	Continued From page 53 to the use of behavior modifying drugs, had not been developed. 2. Individual #4's 3/10 IPP stated he was a 13 year old male whose diagnoses included mild mental retardation, bipolar mixed with psychotic features, ADHD, and mood disorder. Individual #4's record documented he received Prolixin (an antipsychotic drug) 5 mg in the morning and 10 mg in the evening, Depakote (an anticonvulsant drug) 500 mg twice daily, and Lithium Carbonate (a central nervous system drug) 300 mg twice daily. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated Prolixin, Depakote, and Lithium Carbonate were for his bipolar disorder. The Administrator stated Individual #4's bipolar disorder presented as mania, agitation, tantrums including screaming, kicking, and spitting, aggression, and destruction of property. The Administrator stated Individual #4's mood disorder presented as inappropriate emotional responses. The Administrator stated plans related to the use of Prolixin, Depakote, and Lithium Carbonate had not been developed for Individual #4. 3. Individual #3's IPP, dated 4/10, documented a 14 year old male diagnosed with mild mental retardation, pervasive developmental disorder, schizoaffective disorder, ADHD, and OCD. His record documented he received received Thorazine (an antipsychotic drug) 100 mg three timer per day, Abilify (an antipsychotic drug) 30 mg each night, and Trazodone (an antidepressant drug) 150 mg each night. However, his record	W 312		

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W 312	Continued From page 54 did not contain a plan related to the use of the drugs. When asked, the Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., there was no plan related to his behavior modifying drugs. 4. Individual #1's IPP, dated 3/10, documented a 15 year old male diagnosed with mild mental retardation, ODD, ADHD, schizoaffective disorder, reactive attachment disorder, and fetal alcohol effect. His record documented he received Prolixin (an antipsychotic drug) 7.5 mg twice daily and Risperdal (an antipsychotic drug) 1 mg three times daily. Individual #1's record did not contain a plan related to the use of Prolixin. When asked, the Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., a plan for Prolixin was not developed for Individual #1. The facility failed to ensure plans were developed for Individuals #1 - #4's behavior modifying drugs.	W 312		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure routine tardive dyskinesia evaluations were conducted for	W 322		

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W 322	Continued From page 55 3 of 4 individuals (Individuals #1, #3, and #4) whose behavior modifying drugs were reviewed. This resulted in the potential for individuals' health needs to not be met. The findings include: 1. Individual #1, #3, and #4's records documented they were receiving behavior modifying drugs, as follows: - Individual #1 received Prolixin (7.5 mg two times daily) and Risperdal (1 mg three times daily). - Individual #3 received Abilify (30 mg at bed time) and Thorazine (100 mg three times daily). - Individual #4 received Prolixin (5 mg in the a.m. and 10 mg in the p.m.). The Nursing 2008 Drug Handbook stated Prolixin, Risperdal, Abilify, and Thorazine had potential to cause tardive dyskinesia (repetitive and involuntary muscle movements caused by long term use of antipsychotic drugs) and stated individuals taking these drugs should be monitored for tardive dyskinesia. However, Individual #1, #3, and #4's records did not include documentation of tardive dyskinesia evaluations. When asked, the LPN and Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., all staff were trained to monitor for signs of tardive dyskinesia. However, evaluations had not been completed. The facility failed to ensure tardive dyskinesia evaluations were completed for Individuals #1, #3, and #4 who were routinely receiving	W 322		

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W 322	Continued From page 56 antipsychotic medications.	W 322		
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the pharmacist conducted comprehensive drug regimen reviews with accurate input from the IDT for 4 of 4 individuals (Individuals #1 - #4) whose pharmacy consultations were reviewed. This resulted in the potential for negative health outcomes due to inaccurate medication documentation. The findings include: 1. An in-depth record review was conducted at the facility on 4/21/10 from 9:00 a.m. - 3:50 p.m., for Individuals #1 - #4. At that time, documentation of pharmacy reviews could not be found. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the LPN stated the pharmacy reviews were kept in a separate location. The LPN provided a single sheet, dated 4/7/10, which stated "Prescriptions Delivered To [Facility Name]" that listed all individuals residing in the facility and their medications which were delivered by the pharmacy. The LPN stated the list of medications arrived with the medication delivery and she then checked the sheet against the prescriptions, signed the sheet, and sent the sheet back to the pharmacy. The pharmacist did not visit the facility, review	W 362		

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W 362	Continued From page 57 records, review labs, review medication changes, review behavioral data, or receive input from the IDT regarding individuals' medications and their effects. The facility failed to ensure complete information was present for pharmacy reviews, and that the pharmacist completed a thorough review of each individuals drug regimen.	W 362		
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure drugs were stored securely for 8 of 8 individuals (Individuals #1 - #8) residing at the facility. This resulted in controlled drugs not being kept under a double lock system. Findings include: 1. During an environmental review on 4/22/10 from 10:00 a.m. - 12:20 p.m., the following medications were found under single lock in the medication cabinet: - Individual #6's APAP with Codeine (a pain drug) 300-30 mg, one blister pack containing 17 tablets. - Individual #7's Concerta (a stimulant drug) 54 mg, one blister pack containing 25 tablets. The United States Drug Enforcement Administration (www.usdoj.gov/dea) listed APAP with Codeine as a Schedule III controlled drug and the Nursing 2008 Drug handbook stated	W 381		

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W 381	Continued From page 58 Concerta was a Schedule II controlled drug. The RSM, who was present during the review, stated she was not aware that controlled drugs needed to be under a double lock system. The facility failed to ensure all controlled drugs were stored under a double lock system.	W 381		
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all drugs and biologicals were maintained under locked conditions. This failure directly impacted 2 of 8 individuals (Individuals #1 and #4), and had the potential to impact 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the potential for harm in the event individuals accessed and ingested a drug. The findings include: 1. An environmental review was conducted on 4/22/10 from 10:00 a.m. - 12:20 p.m. During that time, the following was found: - In Individual #1's bathroom: 1 tube of Walgreen's hydrocortisone 1% (a topical steroidal cream), 1 box of Compound W One Step Wart Remover (a wart removal drug), 1 tube Target antibiotic ointment (a topical antibiotic drug), 1 bottle T/Sal therapeutic shampoo (a topical dandruff drug), 1 bottle Equate medicated acne	W 382		

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W 382	Continued From page 59 gel (a topical acne drug). - In Individual 4's bathroom: 1 bottle Clean and Clear Advantage acne clearing astringent (a topical acne drug). During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated the drugs should have been locked. The facility failed to ensure all topical drugs were stored under lock and key.	W 382		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure individuals were taught to wear their eyeglasses for 2 of 2 individuals (Individuals #1 and #3) who required eyeglasses for vision and were known to refuse to wear them. This resulted in individuals' not wearing eyeglasses. The findings include: 1. Individual #1's IPP, dated 3/10, documented a 15 year old male diagnosed with mild mental retardation. During a cumulative 5 hours 8 minutes of observation conducted at the facility on 4/19/10	W 436		

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W 436	Continued From page 60 and 4/20/10, Individual #1 was not noted to wear eyeglasses. However, his record included a nursing assessment, dated 3/30/10, which documented he required glasses. Individual #1's IPP did not include a program related to eyeglasses. When asked, the Administrator stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., Individual #1 refused to wear his eyeglasses and he did not have a plan to address his refusals. 2. Individual #3's IPP, dated 4/10, documented a 14 year old male diagnosed with mild mental retardation. During a cumulative 5 hours 8 minutes of observation conducted at the facility, on 4/19/10 and 4/20/10, Individual #3 was not noted to wear eyeglasses. However, his record included a nursing assessment, dated 2/16/10, which documented he required glasses. Individual #3's IPP did not include a program related to eyeglasses When asked, the Administrator, QMRP, and LPN all stated during an interview on 4/22/10 from 3:20 - 8:20 p.m., Individual #3 refused to wear his eyeglasses and he did not have a plan to address his refusals. The facility failed to ensure training plans were developed to teach Individual #1 and #3 to wear	W 436		

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W 436	Continued From page 61 their eyeglasses.	W 436		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses nor identify problem areas. The findings include: 1. The facility opened 8/19/09. During a review of the facility's evacuation drills on 4/22/10, the following was noted: - There were no evacuation drills completed for the first quarter of 2010 (January, February, March), the third quarter of 2009 (July, August, September), or the fourth quarter of 2009 (October, November, December) for the A.M. shift (7:00 a.m. - 3:00 p.m.). - There were no evacuation drills completed for the first quarter of 2010 (January, February, March), the third quarter of 2009 (July, August, September), or the fourth quarter of 2009 (October, November, December) for the graveyard shift (10:00 p.m. - 7:00 a.m.). - There was no evacuation drill completed for the third quarter of 2009 (July, August, September) for the P.M. shift (3:00 - 10:00 p.m.).	W 440		

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W 440	Continued From page 62 When asked during an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated she knew there had been problems with evacuation drills and all required drills had not been completed. The facility failed to ensure evacuation drills were conducted at least quarterly on all shifts.	W 440		
W 447	483.470(i)(2)(iii) EVACUATION DRILLS The facility must file a report and evaluation on each evacuation drill. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain a report on each evacuation drill conducted for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the potential for problems with evacuation drills to go undetected and/or un-addressed. Findings include: 1. The facility opened 8/19/09. During a review of the facility's evacuation drills on 4/22/10, the following was noted: - A Fire Drill Log documented an evacuation drill was conducted on 10/13/09 at 3:35 p.m. - A Fire Drill Log documented an evacuation drill was conducted on 10/17/09 at 3:10 p.m. - A Fire Drill Log documented an evacuation drill was conducted on 3/18/10 at 7:20 p.m. - A Fire Drill Log documented an evacuation drill was conducted on 4/18/10 at 7:00 p.m.	W 447		

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W 447	Continued From page 63 There was no additional documentation of evacuation drills present. The RSM, who was present during the review, stated there was no additional documentation. During an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated some additional drills had been conducted but were not documented. The facility failed to ensure a report was maintained on each evacuation drill conducted.	W 447		
W 455	483.470(I)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases for 5 of 8 individuals (Individuals #1, #2, #5, #6, and #7) residing in the facility. This had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include: 1. An environmental review was conducted in the facility on 4/22/10 from 10:00 a.m. - 12:20 p.m. During that time, it was noted individuals' hygiene kits contained uncovered toothbrushes mixed with other hygiene products as follows: - Individual #1: an uncovered toothbrush was stored in a drawer with a nail trimmer, a razor, a hairbrush, 2 combs, 3 containers of deodorant,	W 455		

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W 455	Continued From page 64 and a tube of acne gel. - Individual #2: four uncovered toothbrushes were stored in a drawer with a razor, hairbrush, ace wrap, hair clips and ties, and a comb. - Individual #5: four uncovered toothbrushes were stored in a drawer with scrap paper, unidentified debris, wall board chips, and a wad of string. - Individual #6: an uncovered toothbrush was stored in a basket with deodorant, a hairbrush, shampoo, detangling spray, a hair pick, and soap. Additionally, an uncovered toothbrush was stored in a drawer with deodorant, two containers of petroleum jelly, and a bottle of baby oil. - Individual #7: an uncovered toothbrush was stored in a basket on the bathroom counter with liquid soap, shampoo, shave cream, conditioner, and deodorant. Additionally, 4 uncovered toothbrushes were stored in a drawer with multiple combs and hairbrushes, lip gloss, shampoo, and a body scrub brush. When asked during an interview on 4/22/10 from 3:20 - 8:20 p.m., the Administrator stated the toothbrushes should have been covered. The facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases.	W 455		

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MM164	16.03.11.075.04 Development of Plan of Care To Participate in the Development of Plan of Care. The resident must have the opportunity to participate in his plan of care. Residents must be advised of alternative courses or care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives must be elicited and considered in deciding on the plan of care. A resident may request, and must be entitled to, representation and assistance by any consenting person of his choice in the planning of his care and treatment. This Rule is not met as evidenced by: Refer to W124.	MM164	See attached Plan of Correction for survey dated 4-23-10. RECEIVED JUN 02 2010 FACILITY STANDARDS	
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W288, W289, and W312.	MM197		
MM203	16.03.11.075.12(a) Treated with Consideration Treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; and This Rule is not met as evidenced by: Refer to W130.	MM203		
MM209	16.03.11.075.15 Right to Personal Items Right to Personal Items. Each resident admitted to the facility must be permitted to retain and use	MM209		

Bureau of Facility Standards Heather Pr Administrator 6/2/10

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G078	A. BUILDING _____ B. WING _____	04/23/2010

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HOME AGAIN ICF	2311 ARUBA DRIVE NAMPA, ID 83686

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MM209	Continued From page 1 his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, and unless medically contraindicated as documented by his physician in his medical record. This Rule is not met as evidenced by: Refer to W137.	MM209		
MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W266.	MM212		
MM213	16.03.11.075.17(b) Training and Habitation Appropriate training and habilitation programs must be provided to residents with hearing, vision, perceptual, or motor impairments in cooperation with appropriate staff; and This Rule is not met as evidenced by: Refer to W436.	MM213		
MM238	16.03.11.080.03(h) Access to Resident's Records To be given access to all of the resident's records that pertain to his active treatment, subject to the requirements specified in Idaho Department of Health and Welfare Rules, Section 05.01.300 through Subsection 05.01.301,06, and Sections 05.01.310 through 05.01.339, "Rules Governing Protection and Disclosure of Department	MM238		

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MM238	Continued From page 2 Records." This Rule is not met as evidenced by: Refer to W250.	MM238		
MM271	16.03.11.100.04(b) Storage of Toxic Chemicals All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure all toxic chemicals were stored under lock and key for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the potential for individuals having access to toxic chemicals. The findings include: 1. During an environmental review on 4/22/10 from 10:00 a.m. - 12:20 p.m., the following toxic chemicals were found to be unlocked: - A bottle of Phillips screen cleaning gel for plasma and LCD screens, containing water, anionic tensid, and Sodium laurel sulfate, was on the shelf in Individual #3's closet. The label stated "Irritant - keep away from children." - Two partial 1 gallon tubs of wall spackle, both labeled "Keep out of reach of children," were located on the floor in the garage. - Two 1 gallon bottles of windshield washer fluid were on the floor of the garage. During an interview on 4/22/10 from 3:20 - 5:20 p.m., the Administrator stated the chemicals should have been locked. The facility failed to ensure all toxic chemicals were properly stored.	MM271		

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MM337	Continued From page 3	MM337		
MM337	16.03.11.110.04(c) Fire Drills A minimum of twelve (12) unannounced fire drills must be held annually, irregularly scheduled throughout all shifts. In addition, a least one (1) drill per shift must be held on a Sunday or holiday. This Rule is not met as evidenced by: Refer to W440.	MM337		
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: During an environmental review on 4/22/10 from 10:00 a.m. - 12:20 p.m., the following was noted: Individual #1's Bedroom: - There was clothing, including sweat pants, socks, shorts, shirts, and pajama bottoms, spread across the floor. - Stuffed animals, books, a tape player, pillows, and bedding were piled on the floor between the dresser and bed.	MM380		

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MM380	Continued From page 4 - There was an 8 inch by 8 inch patched section of wall near the head of the bed that was missing paint. - There was a 5 inch by 5 inch patched section of wall near the head of the bed that was missing paint. - There was a 12 inch by 7 inch patched section of wall behind the door that was missing paint. - The handle on the top dresser drawer was broken. - The desk top was covered with CDs, dirty dishes, and wadded paper. - The door had a 6 inch hole and a 2 inch hole in the bottom edge, a 12 inch break through the bottom panel, and a 4 inch hole above the handle. - There was a 6 inch by 4 inch patched section of wall to the left of the light switch that was missing paint. - There was a 7 inch by 5 inch patched area on the corner wall to the left of the closet that was missing paint. - The closet was missing 1 of the 2 doors. Individual #2's Bedroom: - There was an 8 inch by 12 inch patched section of wall behind the door that was missing paint. - The lock mechanism cover plate in the window frame was missing, exposing sharp screws and other parts underneath. - The bedding and pillows were piled on the floor by the bed. Individual #3's Bedroom: - There was clothing, including a hoodie, shorts, and socks, a wet towel, books and various papers piled on the floor by the door. - There was a 12 inch by 8 inch patched section of wall behind the door that was missing paint. - There was a 4 inch by 6 inch patched section of	MM380		

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MM380	Continued From page 5 wall to the right of the dresser that was missing paint. - The pull knob on the middle dresser drawer was missing, and the second from the bottom drawer was broken from its rail. - There was a pillow and bedding piled on the floor next to the bed. - The window screen was laying on the lawn outside the bedroom window. - There was a brown stain on the edges and center of the pillow case on 1 bed pillow, and the pillow case was missing from another bed pillow. - There was a 6 inch by 3 inch patched area of wall to the left of the closet that was missing paint. - Three of the 4 lights above the bathroom sink were burned out. Individual #4's Bedroom: - The closet doors were missing. - There was a 3 inch by 2 inch hole in the wall behind the door. - One of the dresser drawer pulls was bent. - The bathroom had a strong urine smell. Individual #5's Bedroom: - The closet doors were missing. - There was clothing piled on the floor in the closet. - There was a 12 inch by 12 inch hole in the wall to the left of the bathroom that was partially patched and missing paint. - There was a 12 inch by 18 inch patched section of wall to the right of the dresser that was missing paint. - The bottom right drawer of the dresser was missing, and the middle left drawer was broken and would not open. - The window screen was laying on the lawn outside the bedroom window.	MM380		

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MM380	Continued From page 6 - The wall by the bed had 4 patched sections, measuring 6 inch by 8 inch, 6 inch by 6 inch, 10 inch by 10 inch, and 4 inch by 7 inch, that were missing paint. - There was a 1 inch by 2 inch hole in the bottom of the door. - The toilet paper dispenser was broken from the wall. - The top drawer in the sink cabinet stuck and was difficult to open. Individual #6's Bedroom: - Two of the bathroom drawers were missing. - The toilet paper dispenser was pulled from the wall. - The hand towel rack was broken from the wall mount. Individual #7's Bedroom: - There was a 9 inch break through the door panel by the outside handle. - There was a 2 and 1/2 foot break through the back side of the door. - There was clothing, bedding, and wet towels piled on the floor just inside the door. - There was an empty Gatorade bottle, various pieces of paper, books, a soda bottle, and unidentifiable debris laying on the floor by the dresser. - There were empty potato chip bags and pop cups in the closet, along with clothing piled on the floor of the closet. Individual #8's Bedroom: - There was a 6 inch by 6 inch patched section of wall above the bed that was missing paint. - Multiple slats in the window blind were bent. - The lock mechanism cover plate in the window frame was missing and covered with duct tape. - There was a 12 inch crack in the wall at the	MM380		

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MM380	Continued From page 7 corner to the left of the window. - The closet doors were missing. - There was a wet towel laying on the floor in front of the closet. - The two bed pillows were missing pillow cases. - The bottom dresser drawer was broken into multiple pieces. - There were 3 large empty boxes piled in front of the sink in the bathroom, blocking access. - Two of the three bathroom drawers were missing, and the openings were covered with duct tape. - The toilet paper dispenser was pulled from the wall, and there were two 1 inch holes in the wall. Entryway: - There was a 6 inch by 5 inch patched section of wall that was missing paint. Library: - Multiple slats in the metal blind on the right door were bent. - The door would not remain latched and the wind could be felt blowing around the edges. - There was a 6 inch by 8 inch hole in the base of the wall behind the padded chair. Dinning Area/Living Room: - The ceiling fans were covered with a thick layer of dust. - One of the 4 lights above the table was burnt out. - Two of the dining room chairs had broken rails. - There was food debris and candy wrappers under the cushions of the couch and love seat. Kitchen: - The switch plate to the left of the sink was broken. - There was standing water under the sink.	MM380		

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MM380	Continued From page 8 - The bottom drawer of the oven contained food debris, and the broiler pan contained baked on food. - The oven contained food spills and ash. Shower Room: - The test switch on the electrical outlet was broken. Garage: - The floor was covered by 3 bikes, 5 razor scooters, 2 broken skate boards, 1 dismantled football game, a sled with a rock in it, a broken lawn chair, and a pump, creating trip hazards. Back Yard: - There was a section of fencing just out the back doors that had separated and was leaning into the yard. The facility failed to ensure environmental repairs and cleaning were maintained.	MM380		
MM520	16.03.11.200.03(a) Establishing and Implementing polices The administrator will be responsible for establishing and implementing written policies and procedures for each service of the facility and the operation of its physical plant. He must see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department. This Rule is not met as evidenced by: Refer to W276.	MM520		
MM534	16.03.11.210 Resident Record Requirements A record must be maintained for each resident of	MM534		

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MM534	Continued From page 9 the facility. This Rule is not met as evidenced by: Refer to W111.	MM534		
MM724	16.03.11.270.01(a) Assesments As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to W210.	MM724		
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159 and W249.	MM725		
MM729	16.03.11.270.01(d) Treatment Plan Objectives The individual treatment plan must state specific objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by: Refer to W227.	MM729		

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MM730	Continued From page 10	MM730		
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730		
MM731	16.03.11.270.01(d)(ii) Measurable Behavioral Terms Stated in specific measurable behavioral terms that permit the progress of the individual to be assessed; and This Rule is not met as evidenced by: Refer to W231.	MM731		
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735		
MM753	16.03.11.270.02(f)(i) Locked Area All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by:	MM753		

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MM753	Continued From page 11 Refer to W381 and W382.	MM753		
MM758	16.03.11.270.02(f)(iv) Medication System Monitored The resident's medication system must be evaluated and monitored on a regular basis by a registered nurse and/or a licensed pharmacist. Such evaluations must be done at least every thirty (30) days and records of the evaluation, as well as action taken to correct noted problems, must be kept on file by the facility administrator. This Rule is not met as evidenced by: Refer to W362.	MM758		
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769		

Home Again ICF Plan of Corrections for Survey dated April 23, ~~2009~~ 2010

Federal

Key:

1. ***Describe what corrective actions will be accomplished for those individuals found to have been affected by the deficient practice.***
2. ***Describe how the facility will identify other individuals having the potential to be affected by the same deficient practice and what corrective actions and what corrective actions will be taken.***
3. ***Describes what measures will be put into place or what systematic change will be made to ensure that the deficient practice does not reoccur. How will the corrective actions be monitored to ensure that the deficient practice will not reoccur, ie. Whot quality assurance program will be put inta place.***
4. ***What is the date that the corrective actions will be completed?***

W111

1. For individuals 1-4, records will be obtained and filed for dental, vision, and hearing examinations. For individuals 1-4 counseling notes will be obtained and filed from the Clinical Social Worker. For individual 1, the nursing assessments have been corrected to eliminate any incorrect information. For individuals 1-4, IPP Participant Pages have been added to the updated IPP's and signed by those who attended the meeting. A current IEP will be added to the record of individual #3. For individuals 1-4, written informed consents will be obtained from parents and the facility HRC for all behavior modifying medications. For individual #2 record of the neurological follow up visit, and documentation of a surgical follow up will be added to her records.
2. All residents will have yearly dental, vision, and hearing examinations and records of those examinations will be filed in the resident's medical book. Counseling notes will be obtained from the Clinical Social Worker and placed in the resident files for all residents. All nursing assessments will be reviewed to insure that the information is accurate. IPP participant Pages have been added to all resident IPP's to indicate those individuals that participated in the IPP meetings. All resident IEP's will be reviewed to ensure that the current IEP's are included in the resident records. Written informed consents will be obtained from the parents and HRC for all residents for all behavior modifying medications. The medical records of all residents will be reviewed to ensure that any follow up appointments are scheduled and attended.
3. The nursing staff will review the medical records of all residents monthly to ensure that all medical records are up to date, accurate, and in accordance with regulations, and that all follow up appointments have been attended and recorded. IPP Participant Pages have been added to the IPP forms and the QMRP will ensure that these will be included with all future IPP's. Written informed consents will be obtained from parents and the HRC for each resident for each behavior modifying medications by the nursing staff. The QMRP will review residents records quarterly to ensure that all records including IEP's are up to date and in compliance with regulations
4. All corrections will be complete by June 23, 2010.

W124

1. For individuals 1-4, comprehensive written informed consents in compliance with regulations will be obtained from parents and the facility HRC for all behavior modifying medications and other restrictive

interventions in relation to their PBSP's. Objectives will be included in the Positive Behavioral Support Plan and the Functional Behavior Assessment to include all behaviors treated by behavior modifying medications.

2. All resident's PBSP's will be reviewed to ensure that comprehensive written informed consents in compliance with regulations will be obtained from parents and the facility HRC for all behavior modifying medications and other restrictive interventions in relation to their PBSP's and objectives are included in the Positive Behavioral Support Plan and the Functional Behavior Assessment to include all behaviors treated by behavior modifying medications.
3. The QMRP will work with the nursing staff to write comprehensive written informed consents in compliance with regulations for all behavior modifying medications and other restrictive interventions in relation to their PBSP's at least quarterly, whenever the PBSP's are updated. They will also ensure that PBSP objectives and Functional Behavioral Assessments are included for any behaviors treated by new behavior modifying medications.
4. All corrections will be complete by June 23, 2010.

W130

1. Velcro Curtains were installed in individual #3 and #5's bedroom in order to provide privacy. Velcro Curtains will be installed in Individual #5's bathroom to provide added privacy.
2. The other resident's rooms will be checked to ensure that blinds or curtains are in place to protect the privacy of all residents.
3. The Charge staff will check weekly to ensure that all resident's rooms have curtains or blinds on the windows and bathrooms to ensure privacy.
4. All corrections will be complete by June 23, 2010.

W137

1. All resident grooming kits have been placed in the resident rooms and residents now have full access to their grooming kits. Staff were trained during an in-service held on May 14, 2010 by the QMRP on appropriate interventions for resident #4 when he is physically aggressive and the importance of following the PBSP and not taking away his toys.
2. All resident grooming kits have been placed in the resident rooms and residents now have full access to their grooming kits. Staff have been trained during an in-service held on May 14, 2010 by the QMRP on the importance of not restricting access to personal belongings as a consequence for mal-adaptive behavior.
3. The QMRP and Assistant QMRP will monitor and train staff through out the year to ensure that resident have access to their personal belongings.
4. All corrections will be complete by June 23, 2010.

W159

1. Monthly QMRP notes and evaluations on IPP and PBSP objectives will be kept for every resident and filed in the resident's files. Refer to W111, W124, W137, W210, W214, W227, W231, W249, W250, W288, W289, W312, and W436 for other corrections that will be made.
2. All resident files will be completely evaluated to ensure that they have all information required by the regulations. Refer to W111, W124, W137, W210, W214, W227, W231, W249, W250, W288, W289, W312, and W436 for other corrections that will be made.

3. The QMRP and AQMRP will do Quarterly evaluations of the resident files to ensure that they are complete and in compliance with regulations.
4. All corrections will be complete by June 23, 2010.

W210

1. For individuals 1-4, PT and OT evaluations will be added to the record, and functional behavior assessments (FuBA) will be added or amended to be comprehensive.
2. PT, OT, and FuBA will be added to the records of all residents if they are not currently in their records.
3. In the future, the nursing staff will ensure that all new residents will have evaluations with in the first 30 days of admittance in compliance with regulations. The QMRP or AQMRP will review behavior data monthly and write functional Behavior Assessments for any new mal-adaptive behaviors.
4. All corrections will be complete by June 23, 2010.

W214 Refer to Credible Allegation dated 5-27-10.

W227 Refer to Credible Allegation dated 5-27-10.

W231

1. For individuals 1-4, IPP objectives will be reviewed and amended if necessary to ensure that they are measurable. Objectives will be added to the IPP's if necessary to address all identified priority needs.
2. All of the IPP's for the other residents will be reviewed by the QMRP and amended if necessary to ensure that they are measurable. Objectives will be added to the IPP's if necessary to address all identified priority needs.
3. All future IPP's or IPP updates will be reviewed by the QMRP and/or Administrator to ensure that the objectives are measurable and reflect IDT identified priority needs.
4. All corrections will be complete by June 23, 2010.

W234 was not cited.

W249 Refer to Credible Allegation dated 5-27-10.

W250

1. For individuals 1-4, Active Treatment Schedules were created or amended to ensure that they are individualized, contain staff instructions, contain individual likes and dislikes, give direction for what to do if the individuals finish early, and give instructions on what to do if the individuals refuse.
2. Active Treatment Schedules were created or amended as needed for all other residents to ensure that they are individualized, contain staff instructions, contain individual likes and dislikes, give direction for what to do if the individuals finish early, and give instructions on what to do if the individuals refuse.
3. The QMRP or AQMRP will ensure that the Active Treatments are updated as needed according to the changing needs and preferences of the residents. They will also ensure that comprehensive Active Treatment Schedules are created with in 30 days for any new residents.
4. All corrections will be complete by June 23, 2010.

W266 Refer to Credible Allegation dated 5-27-10.

W276 Refer to Credible Allegation dated 5-27-10.

W288 Refer to Credible Allegation dated 5-27-10.

W289 Refer to Credible Allegation dated 5-27-10.

W312

1. For individuals 1-4, PBSP objectives have been created or revised to include objectives for behaviors treated by behavior modifying medications and Medical Plans of Reduction for all behavior modifying medications have been added or amended if needed.
2. For all other residents, PBSP objectives have been created or revised if needed to include objectives for behaviors treated by behavior modifying medications and Medical Plans of Reduction for all behavior modifying medications have been added or amended if needed.
3. The QMRP and Nursing staff will work closely together to monitor and document the resident's mal-adaptive behaviors and work toward reducing all behavior modifying medications for all current and future residents.
4. All corrections will be complete by June 23, 2010.

W322

1. For individuals 1, 3, and 4, Tardive Dyskinesia (TD) evaluations will be completed and documented.
2. Tardive Dyskinesia evaluations will be completed and documented for all other resident who are taking medications that have the potential side effect of TD.
3. TD evaluations have been attached to the quarterly nursing assessments and will be completed and documented quarterly as a part of the nursing assessments.
4. All corrections will be complete by June 23, 2010.

W362

1. For individuals 1-4, in depth, onsite pharmacy reviews will be performed and documented.
2. For individuals all current residents, in depth, onsite pharmacy reviews will be performed and documented.
3. The nursing staff will ensure that in depth, onsite pharmacy reviews will be performed and documented quarterly in the future.
4. All corrections will be complete by June 23, 2010.

W381

1. A second lock was installed on the medication cabinet to ensure that all resident medications are secure.
2. A second lock was installed on the medication cabinet to ensure that all resident medications are secure.
3. The nursing staff will ensure that the medication cabinet is double locked at all times.
4. All corrections will be complete by June 23, 2010.

W382

1. For individuals 1 and 4, all medicated and biological materials will be locked up and recorded.
2. All other medicated and biological materials will be locked up and recorded if needed.

3. Nursing staff will keep a log of all medicated and biological materials and Charge staff will check weekly to ensure that all such materials are locked.
4. All corrections will be complete by June 23, 2010.

W436

1. For individuals 1 and 3, IPP objectives were added to address care and use of eye glasses.
2. IPP objectives were added to address care and use of eye glasses for each resident that has been prescribed eye glasses.
3. QMRP and Nursing staff will work closely together to ensure that IPP goals and staff instructions are in place to assist the residents in the care and use of all prescribed medical equipment.
4. All corrections will be complete by June 23, 2010.

W440

1. Fire and evacuation drills have been completed, evaluated, and recorded for each shift in this quarter.
2. Fire and evacuation drills have been completed, evaluated, and recorded for each shift in this quarter.
3. The RSM will ensure that Fire and evacuation drills are completed, evaluated, and recorded for each shift in each quarter
4. All corrections will be complete by June 23, 2010.

W447

1. Fire and evacuation drills have been completed, evaluated, and recorded for each shift in this quarter.
2. Fire and evacuation drills have been completed, evaluated, and recorded for each shift in this quarter.
3. The RSM will ensure that Fire and evacuation drills are completed, evaluated, and recorded for each shift in each quarter
4. All corrections will be complete by June 23, 2010.

W455

1. For the identified individuals, tooth brush covers were purchased and put on the toothbrushes to prevent the spread of disease.
2. Tooth brush covers were purchased and put on the toothbrushes for all other residents to prevent the spread of disease.
3. The direct Charge Staff will ensure that all residents are using their toothbrush covers and that all covers are clean.
4. All corrections will be complete by June 23, 2010.

Home Again ICF Plan of Corrections for Survey dated April 23, ~~2009~~ 2010

State

Key:

1. ***Describe what corrective actions will be accomplished for those individuals found to have been affected by the deficient practice.***
2. ***Describe how the facility will identify other individuals having the potential to be affected by the same deficient practice and what corrective actions and what corrective actions will be taken.***
3. ***Describes what measures will be put into place or what systematic change will be made to ensure that the deficient practice does not reaccur. How will the corrective actions be monitored to ensure that the deficient practice will not reaccur, ie. What quality assurance program will be put into place.***
4. ***What is the date that the corrective actions will be completed?***

MM164 see W124.

MM197 see W288, W289, and W312.

MM203 see W130

MM209 see W137

MM212 see W266

MM213 see W436

MM238 see W250

~~MM217~~ MM271

1. All hazardous materials will be locked up and recorded.
2. All hazardous materials will be locked up and recorded.
3. The RSM will keep a log of all hazardous materials and Charge staff will check weekly to ensure that all such materials are locked.
4. All corrections will be complete by June 23, 2010.

MM337 see W440

MM380

1. All repairs to the facility will be completed as outlined in the survey report.
2. All repairs to the facility will be completed as outlined in the survey report.
3. The Charge staff will make a list weekly of needed repairs to the facility and RSM will ensure that the facility repairs are completed in a timely manner.
4. All corrections will be complete by June 23, 2010.

MM520 see W276

MM534 see W111

MM724 see W210

MM725 see W159 and W249

MM729 see W227

MM730 see W214

MM731 see W231

MM735 see W322

MM753 see W381 and W382

MM758 see W362

MM769 see W455